

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS

JUE ZHANG)	
Plaintiff)	
)	
v.)	CIVIL ACTION NO. 04-12735-PBS
)	
SHRAGA N. GOLDBERG, M.D.)	
Defendant)	

PLAINTIFF'S OPPOSITION
TO MOTION OF THE DEFENDANT SHRAGA N. GOLDBERG, M.D.,
FOR COURT ORDERS TO OBTAIN DOCUMENTS FROM
THE DEPARTMENTS OF THE UNITED STATES GOVERNMENT

NOW COMES THE PLAINTIFF, and opposes the defendant's motion for Court orders to obtain documents from the departments of the United States government.

ARGUMENT

1. The crux of this medical malpractice case is whether Shraga N. Goldberg, M.D. breached the standard of care by failing to identify an abnormality on a CT scan of November 7, 2001 which was later diagnosed as tuberculosis. (See attached Exhibit 1)
2. In support of the plaintiff's claim, please refer to the report of Michael E. Swirsky, M.D., who on June 20, 2003 reviewed the above scan of November, 2001 (for the purpose of treatment, not litigation) and described the abnormality. (See attached Exhibit 2)
3. Although the plaintiff at her deposition did not remember which tests she had prior to entering the United States on a student visa in 1997, that information is contained in the medical records, dictated by Cameron Ashbaugh, M.D., her treating physician. (See attached Exhibit 3) The records show that the plaintiff in 1997 had a positive PPD for tuberculosis but received no treatment. In addition, she has had negative chest x-rays since October 1, 2001. (See attached Exhibit 4)
4. Dr. Ashbaugh opines as plaintiff's expert that the missed diagnosis allowed the tuberculosis to progress to vertebral destruction requiring surgery which could otherwise have been successfully treated medically. (See attached Exhibit 5)
5. No medical information that may be contained in the government's documents that defense counsel is requesting could assist in Dr. Goldberg's defense. The only information he was given as a history by the requesting physician for the CT was "right upper quadrant pain" (See attached Exhibit 1) If Dr. Goldberg or the referring physician had taken a proper history, they would have discovered that the plaintiff had a positive

PPD on entering the United States, whether or not that information is contained in the requested government documents.

6. Additionally, in 1998, upon entering graduate school at Northeastern University, the plaintiff had a positive PPD. (as described in defendant's motion, Fact # 4) The referring physician and Dr. Goldberg failed to obtain a proper history since they would have learned of the results of that test.
7. If obtaining a proper history would have allowed Dr. Goldberg to make the correct diagnosis, he failed to do so. Certainly the plaintiff did not have her applications to enter the United States with her on those doctor's office visits, and therefore any information they contained would be irrelevant to this inquiry.
8. Defense counsel's request is a not so thinly-veiled attempt to intimidate the plaintiff into dismissing her lawsuit, as evidenced by counsel's attempt to obtain immigration records of her husband as well, who is not a party to this lawsuit.
9. Any interrogation of a governmental agency responsible for issuing green cards (plaintiff's application is pending), especially at this time in our history, will raise eyebrows, which is unduly prejudicial to the plaintiff's application process.
10. Given that there is no information in those records that could possibly benefit the defendant regarding his missed diagnosis, and given the likelihood of an adverse effect on the plaintiff's application, this request must, for fairness, be denied.
11. Even if the requested records reveal incorrect medical information regarding the presence or absence of a PPD or other medical history, that does not necessarily prove or disprove the plaintiff's veracity, but may be an error in memory, mistaken belief, or otherwise. There are many ways to test veracity short of the draconian results this inquiry may cause the plaintiff. Finally, her veracity has no bearing at all upon Dr. Goldberg's negligence, causation or damages.

CONCLUSION

For the foregoing reasons, the Court should deny the defendant's motion for orders to obtain documents from the departments of the United States government.

The plaintiff,
by her attorney,

_____/S/ Barry D. Lang, Esq.
Barry D. Lang, Esq.
BBO # 565438
Zachary B. Lang, Esq.
BBO# 652055
Attorney for the Plaintiffs
Barry D. Lang, M.D. & Associates
1 State Street, Suite 1050
Boston, MA 02109
617-720-0176

BETH ISRAEL DEACONESS MEDICAL CENTER
Department of Radiology

ANG, JUE	F 28 (09/06/73)	156-93-12
GUAN, RONG J.	OPT	11/07/01 2:47 PM
CT ABDOMEN W/CONTRAST; CT PELVIS W/CONTRAST		Clip # 278-3030
Reason: RUQ PAIN		
Field of view: 33 Contrast: CONRAY		

FINAL REPORT

HISTORY: Right upper quadrant pain.

No prior studies available for comparison.

TECHNIQUE: Helically acquired contiguous axial images were obtained from the lung bases to the pubic symphysis after the administration of 150 cc of intravenous contrast without complication.

CT OF THE ABDOMEN WITH IV CONTRAST: There are no nodules or focal infiltrates in the lung bases. There are no pleural effusions. The liver, gallbladder, spleen, adrenal glands, and pancreas are normal in appearance. There is a small hypodense lesion which does not enhance within the right kidney, which is too small to characterize but most likely represents a simple cyst. The left kidney is normal in appearance, as are the ureters bilaterally. The visualized small and large bowel within the abdomen are unremarkable, with no wall thickening or adjacent fat stranding. There are several non-pathologically enlarged lymph nodes in the mesentery. There is no retroperitoneal lymphadenopathy. There is no free fluid or free air in the abdomen.

CT OF THE PELVIS WITH IV CONTRAST: The distal ureters, bladder outline, uterus, ovaries, rectum, sigmoid colon, and visualized small bowel loops within the pelvis are normal in appearance. There is no inguinal or pelvic lymphadenopathy. There is no free fluid in the pelvis.

There are no significant osseous abnormalities.

IMPRESSION: Normal CT of the abdomen and pelvis with no evidence of pathological process.

ZRY

THE STUDY AND THE REPORT WERE REVIEWED BY THE STAFF RADIOLOGIST.

DR. MICHAEL P. GOLDFINGER

DR. SHRAGA N. GOLDBERG

Approved: THU NOV 8, 2001 12:26 PM

Date Mailed: 11/09/01

RADLINE 667-5555, ID 1079; A radiology consult service.
To hear preliminary results, prior to transcription, call the
Radiology Listen Line 667-7834.



RADIOLOGY
& IMAGING, INC.

Date of Exam: 6/20/2003 8:59:00 AM

ZHANG, JUE
E26 MILLPOND RD
BROAD BROOK, CT 06016

HOWARD RO, MD
701 ENFIELD STREET
ENFIELD, CT 06082

SS No: 030809933
Date of Birth: 12/6/1973
X-Ray No: 7124298
Account No: EN2477745
Accession #: 000000014770

Description: 08185CT THORACIC SPINE

CT SCAN OF THE THORACIC SPINE

History: Back pain, abnormal thoracic spine radiographs.

2 mm thick sections were obtained from the mid portion of T8 through the T10-T11 intervertebral disc space. Comparison is made with thoracic spine radiographs of 6/18/03.

There is moderate osseous erosion along the right anterolateral and lateral aspects of the T8 vertebral body. There is extensive osseous destruction within the inferior portion of the T9 vertebral body extending through the inferior endplate. There is substantial fragmentation within the vertebral body, especially anteriorly, with osseous erosion extending close to, but not extending through, the posterior vertebral margin. There is no apparent involvement of the spinal canal. Irregularity extends across the T9-T10 intervertebral disc space, which is narrowed. There is milder osseous erosion along the right anterior aspect of the T10 vertebral body but this appears to terminate above the level of the T10-T11 intervertebral disc space. No other osseous abnormality is present. There is extensive abnormal soft tissue thickening anteriorly and along the right side of the spine from the T8 through T10 levels, most severe at and just above the level of the T9-T10 disc space. Maximum thickness of this soft tissue is approximately 1.7 cm. It is of slightly lesser thickness at the T8 level and is markedly less thick at the T10 level. Comparison with a Beth Israel Deaconess Medical Center CT scan of 11/7/01 demonstrates there was some abnormal paraspinal soft tissue thickening in the lower thoracic region at that time, although not quite as prominent as in the current examination. There are no bone window images from the prior study for review. It is noted that thoracic spine radiographs dated 10/2/01 from MetroWest medical center in Framingham do not demonstrate the destructive changes apparent in the recent thoracic spine radiographs.

No other osseous or soft tissue abnormality is present.

Impression: Osteomyelitis of the spine extending from T8 through T10 with extensive bone destruction within the inferior portion of the T9 vertebral body and lesser osseous destruction along the right side of both the T8 and T10 vertebral bodies. Discitis at the T9-T10 level with loss of disc height. Extensive paraspinal soft tissue



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ZHANG, JUE

000000014770

thickening consistent with inflammation.

CT guided biopsy is recommended to obtain material for culture. Note is made that the patient is a native of China and reports being PPD positive. Tuberculosis is a possible etiology of the observed spinal abnormalities and acid-fast staining and TB culture of the biopsy material is strongly recommended. Findings were discussed with Dr. Ro immediately following the examination.

The report was faxed to the referring physician's office.

Signed by: Michael E. Swirsky, MD
Date: Friday, June 20, 2003
Time: 17:04:28

BRIGHAM AND WOMEN'S HOSPITAL
HARVARD TEACHING AFFILIATE
BOSTON, MASSACHUSETTS 02115

178-80-88-1

ZHANG, JUE

BRIGHAM MEDICAL SPECIALTIES

Note for visit on 09/02/03

NOTE:

ID clinic
BWH
Staff note

Ms. Zhang comes to ID clinic after in patient consultation. Pt is a 29 yo woman born and raised in China who emigrated to the United States in 1997. PPD reported positive at that time but patient did not receive therapy. Pt evaluated in the spring of this for several years of slowly progressive and intermittent back pain. Noted to have T9-T10 abnormality. Pt had needle biopsy in 6/03 at Bay State medical center. AFB on pathologic material. Pt begun on INH/Rif/EMB/PZA for presumed tuberculosis. Cultures of biopsy material probed positive for both M. TB and MAC. Some decrease in pain over ensuing 6 weeks, but continued to have sweats at night. Admit 7/29 for evaluation of spine stability and possible need for surgery. MRI demonstrated anterior vertebral abscess/phlegmon T8-T11, T9T10 discitis with endplate erosion, mild epidural soft tissue mass extension without chord compression, and increased T2 signal in vertebral bodies T8-T11. Cxr was negative and sputum stains for afb were negative. Pt was felt to be stable without the need for surgery. Because of continued sweats and malaise, antimycobacterial regiment was modified in mid august: rifabutin substituted for rifampin and clarithromycin added. Shortly after institution of new medications pt developed nausea, diarrhea, perhaps faint rash and escalating temperatures. At that time had scheduled eye exam, after receiving one of the eye drops for the exam began to feel worse. Developed fever to 102, increasing headache. Admit 8/23 BWH. Extensive workup including LP unrevealing. MRI without significant change, perhaps a little better. Fevers resolved, although pt had developed relative neutropenia that persisted. Dcd home 8/26. Shortly thereafter, rash that may have been present for a week became more prominent, puritic. In setting of rash and neutropenia, rifabutin held. Pt comes in now with continued rash, but generally feeling better. Back pain is slowly decreasing, and no sweats at night. She says she is compliant with her medications.

PMH

1. Spine infection: M. TB and MAC.

Meds

INH 300 mg qd
B6 50 mg qd
Ethambutol 1200 mg qd
Pyrazinamide 1000 mg qd
MVI qd
Calcium 2 capsules qd

FH

Uncle and grandfather both with symptomatic tuberculosis, although pt reports their illnesses had resolved by the time she had contact with them. Husband was treated for latent tuberculosis prior to her meeting him.

SH

Married. 6 month old daughter. Works as a computer specialist. Lives in northern Connecticut.

PE WT 136 (shoes and brace) P 60 BP 100/70 T 94.8
Gen: Appears well
HEENT: Anicteric. No oral lesions

MetroWest Medical System
 Framingham Union Hospital
 115 Lincoln St., Framingham, MA 01702
 (508) 383-1300

Leonard Morse Hospital
 67 Union St., Natick, MA 01760
 (508) 650-7333

MetroWest Wellness Center
 761 Worcester Rd., Suite 101
 Framingham, MA 01701 CAMPUS
 (508) 271-2001

MetroWest Professional & Medical Center
 321 Fortune Blvd.
 Milford, MA 01757 (508) 634-4940

**Report
 By
 MetroWest
 Radiology
 Associates**

NAME: ZHANG, JUE
 PHYS: KIM, JOHNNY J
 DOB: 12/06/1973 AGE: 27 SEX: F
 ACCT: 4841267 LOCATION: 506F B
 EXAM DATE: 10/01/2001 AT:
 RADIOLOGY NO:
 UNIT NO: 05373514
 PHONE #: (508)231-4513

RADIOLOGY REPORT

DX:

RUC ABD PAIN- KUB

EXAMS: 000635705 ABDOMEN, SINGLE AP,
 000635706 CHEST, PA OR AP & LATERAL,
 000635709 RIBS, UNILAT, 2 VIEWS,
 000635710 THORACIC SPINE/2 VIEWS

10/01/01

74000 71020 71100 72070

CHEST: The heart and pulmonary vessels are unremarkable. There are no focal pulmonary infiltrates or pleural effusions. No hilar or mediastinal lymphadenopathy is seen. There is no focal skeletal abnormality.

THORACIC SPINE: There is no focal bony lesion, evidence of acute compression fracture or subluxation. The paravertebral soft tissues are unremarkable.

RIGHT RIBS: There is no focal rib lesion or evidence of acute fracture.

ABDOMEN: The bowel gas pattern is unremarkable. There are no dilated loops of small bowel. Stool is present in the colon. The skeletal structures are unremarkable.

IMPRESSION:

1. NO ACUTE INTRATHORACIC PROCESS.
2. NO EVIDENCE OF FOCAL BONY LESION IN THE THORACIC SPINE.
3. NO FOCAL RIB LESION OR RIB FRACTURE.
4. NONSPECIFIC BOWEL GAS PATTERN.

CC: JOHNNY J KIM; MOHAMMAD M SIDDIQUI

ACR CODE:

TRANSCRIBED DATE/TIME: 10/02/2001 (1414)

TRANSCRIPTIONIST: TRANS.PSD

SENT DATE/TIME: 10/02/2001 (1454)

TECHNOLOGIST: JOANNE WILLIAMS, R.T.R.

BATCH NO: S638

RESULT CODE:

CHITRY RADKIN, M.D.

December 6, 2004

Dr. Barry D. Lang
1 State Street
Suite 1050
Boston, MA 02109

Dear Dr. Lang,

Ms. Jue Zhang has been under my care at Brigham and Women's Hospital from August 2003 for a mycobacterial spine infection. Ms. Zhang was born in China and emigrated to the United States in 1997. She reports that on arrival in the United States she had a skin test for tuberculosis and that she was told that it was positive. In the summer of 2001, she developed pain in the right upper abdomen and back. In September 2001, she made several trips to the Emergency Room at Metrowest Medical Center for evaluation before finally being admitted on 10/01/01. During her admission she had a variety of studies. Reports from these studies record a normal chest x-ray, a normal abdominal x-ray, normal rib x-rays, normal thoracic spine x-rays, and an abdominal/pelvic CT scan that was notable for a possible small cyst in the right ovary. An upper gastrointestinal endoscopy demonstrated findings consistent with mild gastritis. She was discharged on 10/3/01 with a diagnosis of musculoskeletal pain and gastritis. On November 7, 2001, she had an abdominal CT scan done at the Beth Israel Deaconess Hospital. It was reported as a normal study.

She continued to have intermittent back and right side pain that waxed and waned. In June 2003, she initiated care with Dr. Howard Ro in Enfield, Connecticut. On her first visit, Dr. Ro ordered chest and thoracic spine x-rays which demonstrated thoracic vertebral damage that was new in comparison to the x-rays done in 2001. A follow-up spinal CT scan on June 20, 2003 demonstrated findings consistent with a thoracic vertebral spine infection with an associated large paraspinal abscess. Of note, the radiology report compares this CT study to the November 2001 study from the Beth Israel Deaconess Hospital. In retrospect, the radiologist reading the most recent images feels that there was abnormal paraspinal soft tissue thickening in the lower thoracic spine in 2001. The patient underwent needle biopsy of the thoracic spine abnormality on June 26, 2003. The pathology was consistent with mycobacterial infection and the cultures ultimately grew both *Mycobacterium tuberculosis* and *Mycobacterium avium intracellulare* complex. The patient was begun on antituberculous therapy in late June 2003 and in August 2003, additional therapy for *Mycobacterium avium intracellulare* complex was added. Despite medical therapy, she had a slow increase in the size of her paraspinal abscess and thoracic vertebral body infection that was demonstrated by repeated spinal imaging studies over the next nine months.

On April 8, 2004, she underwent a right thoracotomy. In the operating room, approximately 50 ml of purulent material was aspirated from the paraspinal abscess and necrotic bone was debrided. She had a titanium cage and rods placed to stabilize her thoracic spine. A stain of the abscess fluid for mycobacterium species was positive, however, the operative cultures were negative. A PCR test for *Mycobacterium tuberculosis* DNA done on the abscess fluid was positive. A similar test for *Mycobacterium avium intracellulare* complex was negative. The patient has slowly improved since her surgery. She completed medical therapy on 10/15/04.

It is likely that she had slowly progressive mycobacterial spine infection for many years and that the symptoms that prompted her 10/01/01 admission to Metrowest Hospital were due to this infection despite the negative chest, rib, and thoracic spine radiographs that were done at the time. Although the course of these infections is difficult to predict, it is more likely than not that had the diagnosis of spinal tuberculosis been made in 2001, before the disease had progressed to vertebral body destruction and a large abscess, she would have been able to have been treated successfully with medical therapy alone and would not have required surgery

Sincerely,

A handwritten signature in black ink, appearing to read "Cameron Ashbaugh". The signature is fluid and cursive, with the first name "Cameron" written in a larger, more prominent script than the last name "Ashbaugh".

Cameron Ashbaugh, M.D.
Assistant Professor of Medicine
Harvard Medical School
Associate Physician
Brigham and Women's Hospital
Division of Infectious Disease
Boston, MA